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ABSTRACT

Noting that Minnesota has developed many innovative services for parents and infants, but does not yet have an organized way to attend to infants' emotional development and mental health needs, this report details a study to ascertain the need for infant mental health services and examined the current level and types of services available. Data were gathered by means of a mail survey sent to parents and representatives from a variety of professional fields, focus groups held in five communities, and interviews with parents and key people in pivotal positions serving families. Also, a consultant team of community experts and the Center for Early Education and Development at the University of Minnesota reviewed current systems in Minnesota and other states. The report defines infant mental health, presents a conceptual framework for a coordinated system, outlines guiding principles underlying creation and coordination of services, and presents criteria for effective service delivery. The report recommends that infant mental health services be identified and organized as a continuum of activities in four areas: (1) public awareness; (2) education and support; (3) screening; and (4) assessment and intervention. The report also discusses costs and savings related to infant mental health services, policy and program implications, needs assessment results, and infant mental health activities in other states. The report concludes by asserting that a coordinated system of services to support physical and mental health will help ensure that children have a solid developmental foundation. The report's three appendices summarize the study's results and describe services in other states. (Contains 34 references.) (KB)

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MINNESOTA INFANT MENTAL HEALTH SERVICES

FEASIBILITY STUDY

J. Bartlett

SEPTEMBER 1, 1998

Prepared for the _

Minnesota Early Intervention Team representing the
Minnesota Departments of Health, Human Services, and Children, Families & Learning

by

CEED, Center for Early Education and Development
College of Education & Human Development, University of Minnesota

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MINNESOTA INFANT MENTAL HEALTH SERVICES FEASIBILITY STUDY

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MINNESOTA INFANT MENTAL HEALTH SERVICES FEASIBILITY STUDY

Introduction

Minnesota has developed many effective and innovative services for parents and infants, [1] but the State does not yet have an organized way to attend to the emotional development and mental health of its youngest citizens. The recent and profound progress researchers have made in understanding child development, early brain development, and infant/toddler mental health have yet to be fully integrated into our systems of care for young children. This study was sponsored to address these issues and to envision how the diverse communities in Minnesota can work together in building services that attend to the vital mental health needs of infants and toddlers and their families.

Infant mental health is the optimal growth and social-emotional, behavioral, and cognitive development of the infant *in the context of the unfolding relationship between infant and parent.*

—Minnesota Infant Mental Health Services Feasibility Study Consultant Team

In approaching the topic of infant/toddler mental health it becomes clear that this issue touches on all the structures and services that interact with young families. Mental health is not a discrete subject. It involves the interdependence of infant and parent—and of family and community. The mental health of a young child may be affected by any of the agencies and services with which his or her family is involved. At present there is a patchwork quilt of educational, health, social, and human services available to families with young children in most Minnesota communities. And often these systems still work independently of each other. This unstructured mix complicates and compromises efforts to respond to the needs of infants and families in a proactive, coordinated manner. New perspectives have led to the widespread recognition that the health care and developmental needs of infants and their families, including infant mental health, have multiple and interdependent causes and

[1] The range of services available to families in Minnesota is extensive and varies from community to community. Some programs, such as Early Childhood Family Education (ECFE), are unique to the state in that they are universally accessible and provide a variety of services in support of families.

outcomes requiring an integrated response from professionals working in different systems.

Reports from the fields of health, human services and education point toward an increasing concern among professionals about the frequency of problematic parent/child relationships and the resulting behavioral disturbances among young children (Barnard, Morisset, Spieker, 1993). A 1991 national survey of 7,000 kindergarten teachers reported that 35% of children in their classes were not ready for school, with 42% of the teachers reporting that the situation is getting worse. Parallel issues were noted in conversations with Head Start staff and child care providers and administrators conducted during this study. Poverty alone is not necessarily a predictor of mental health problems for a young child, but in combination with other stressors, it can contribute to the problem (Halpern, 1993). Although families with lower incomes are most vulnerable, it is generally accepted that all families are experiencing higher levels of stress. Each risk factor or vulnerability faced by a young family increases the risk that its infant is dealing with a mental health issue.

All the systems and agencies that work with families of infants need to be providing infant mental health services in some capacity... to help parents build a healthy relationship with their child.

—Family Support Program Administrator

The early years provide an important foundation for both mental and physical health throughout life. Recent brain research has greatly enhanced our knowledge of the importance of the first three years of life with regard to brain development and the ability to relate to others. Neuroscientists have found that the nourishment, care, surroundings and stimulation an infant receives during these crucial first years has an impact not only on the general development of the child, but actually affects how the intricate circuitry of the brain is connected (Shore, 1997). The ways that parents, families and other caregivers relate to and respond to young children, and the ways that they support children as they have contact with their environment, directly affect the physical formation of neural pathways in the brain. If a child is exposed to stressful events such as physical abuse, emotional abuse, or neglect, these adverse experiences may result in elevated levels of hormones that may in turn elicit negative changes in both brain activities and brain structures (Gunnar, 1996). Likewise, a strong, secure

relationship[2] with a caregiver can directly determine a child's capacity to control emotions and withstand the stresses of daily life.

For various reasons having to do with either the parent or the infant, some infants experiencing poor relationships with their parents and/or traumatic life circumstances are vulnerable for child abuse and neglect and delayed development. As they grow older, they are at risk for developing antisocial behavior and other behavior that will impair their ability to perform in school and succeed in life. Early brain research has confirmed what parents, medical personnel and other professionals have known for some time—that the first nurturing experiences of a baby with its caregivers and in its home and community set the stage for its healthy growth and development.

We must examine the ways in which we support young families to guarantee that we are most effectively supporting the parent/child relationship and a strong and healthy family unit. We must open our scrutiny to make sure that each professional or system that interacts with the family plays a coordinated and positive role in concert with others. To be most effective, our concerns for children must extend from the prenatal period, through birth, and on through childhood to guarantee their optimal development. Our systems for delivering supports to families must likewise be increasingly flexible and give attention to both what is needed and when it is needed, in order to facilitate the best outcomes for all children.

The lack of a coordinated system of services for young families exacts a high price for the children, the families, and for society as a whole. Specialized infant mental health services, which can "back up" persons providing less intensive services and intervene directly in the most problematic situations, can result in cost savings in a wide range of areas, including use of emergency rooms, costs incident to child abuse and neglect, special education, and delinquency (Tableman, 1995).

Sometimes the baby's mental health determines the relationship. You can't have a "normal" relationship with a brain-damaged child. A child who has brain-difference is not going to interact with parents in the same way. (Likewise) prematurity is something that interferes with psychological process. The baby can't respond normally.

—Parent

[2] At times the word "relationship" has been used in place of "attachment" in this report.

Research over the past 30 years has contributed to an understanding of ways in which all professionals working with infants and their families can promote parent-infant relationships and provide appropriate interventions for the most problematic situations. Specific services to support infant mental health are in place or under development in such states as Michigan, South Carolina, Texas, Ohio, and Arizona.

In response to the critical need for services that support families with infants, the Minnesota State Early Intervention Team selected CEED, the Center for Early Education and Development in the College of Education and Human Development at the University of Minnesota, to conduct a Feasibility Study on an Infant Mental Health Services Framework for the State of Minnesota. The Early Intervention Team is comprised of representatives from the Minnesota Departments of Health, Human Services, and Children, Families and Learning who work together on cross-agency initiatives that coordinate programs serving young children and their families.

This study was commissioned partly in response to the provisions of Part C (formerly Part H) of IDEA, the Individuals with Disabilities Education Act. Part C is the Infants and Toddlers with Disabilities Program, which, among other things, includes in the definition of children eligible for services those who are identified as having "a diagnosed physical or mental condition that has a high probability of resulting in developmental delay." The regulations give examples of these conditions, including "severe attachment disorders," which reflect serious problems and insecurity in the relationship between infant and parent.[3] A disturbance in secure attachment between infant and parent compromises the infant's later developmental mastery, including the capacity for interpersonal relationships.

To accomplish this study, CEED convened an interdisciplinary Consultant Team consisting of community experts representing a variety of fields and perspectives, including parents. Data for the study was

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[3] The term "parent" refers to biological parents but may include other primary caregivers such as foster parents, grandparents, and others.

gathered by means of a paper survey sent to parents and representatives from a variety of professional fields across the state, a series of focus groups held in five diverse Minnesota communities, and interviews with parents and key people in pivotal positions who serve families. In addition, the Consultant Team and CEED reviewed what infant mental health services are currently in place in Minnesota and what service delivery models exist in other states. The recommendations in this report are a result of this process.

A Definition of Infant Mental Health

In spite of its tremendous importance and the great strides in theory and research in recent years, there is, as of yet, no single agreed-upon definition of infant mental health. For the purposes of this study the following definition of infant mental health was developed by the Minnesota Infant Mental Health Feasibility Study Consultant Team.

Infant mental health is the optimal growth and social-emotional, behavioral, and cognitive development of the infant in the context of the unfolding relationship between infant and parent.

Infant mental health recognizes that the infant's emerging self unfolds in relation to the parent and that both are imbedded in a complex environment that may impact their ability to relate to each other. Infant mental health is compromised by **risk factors** and vulnerabilities that impact optimal development. Research has shown us that environmental factors such as poverty, family or community violence, teenage parenthood, parental depression or mental illness, social isolation, and a parent's history of poor parenting, child abuse, or chemical dependency may negatively impact the infant's mental health. Vulnerabilities of the infant such as genetic, congenital, or medical conditions (e.g. autism, cerebral palsy, downs syndrome), prenatal drug or alcohol exposure, premature birth, difficult temperament, and problems in feeding or sleeping may impede the development of optimal mental health.[4]

[4] Infant mental health disorders include, but are not limited to, disturbances in secure attachment between infant and parent. Disordered attachment compromises later developmental mastery, including the capacity for interpersonal relationships. Other infant

Protective factors in an infant's life can buffer risk and vulnerabilities to promote mental health. Parental capacities such as sensitivity, empathy, developmentally appropriate expectations for the growing infant, having and maintaining trusting relationships, and seeking and using available resources can protect the infant. Other protective factors that mediate the impact of stress on the parent and provide alternative relationships for the infant include a supportive extended family and social network. A secure relationship between infant and parent, which is mutually responsive and satisfying, promotes a sense of trust and well-being in the infant which is the foundation for later feelings of competence and healthy autonomy.

Without counterbalancing protective factors or community services, infants exposed to environmental risks or presenting vulnerabilities show impaired growth and development. Such infants are more likely to be ill, to experience neglect and abuse, to be delayed in developing speech, to be depressed, to be aggressive, and to be unable to trust or relate to other people.

We need to look at the whole systems and adopt a systems approach. Programs fail by being too narrow. Families are isolated, hence we need to construct support systems within the neighborhood or community.

—Child Care Administrator

Conceptual Framework for a Coordinated System

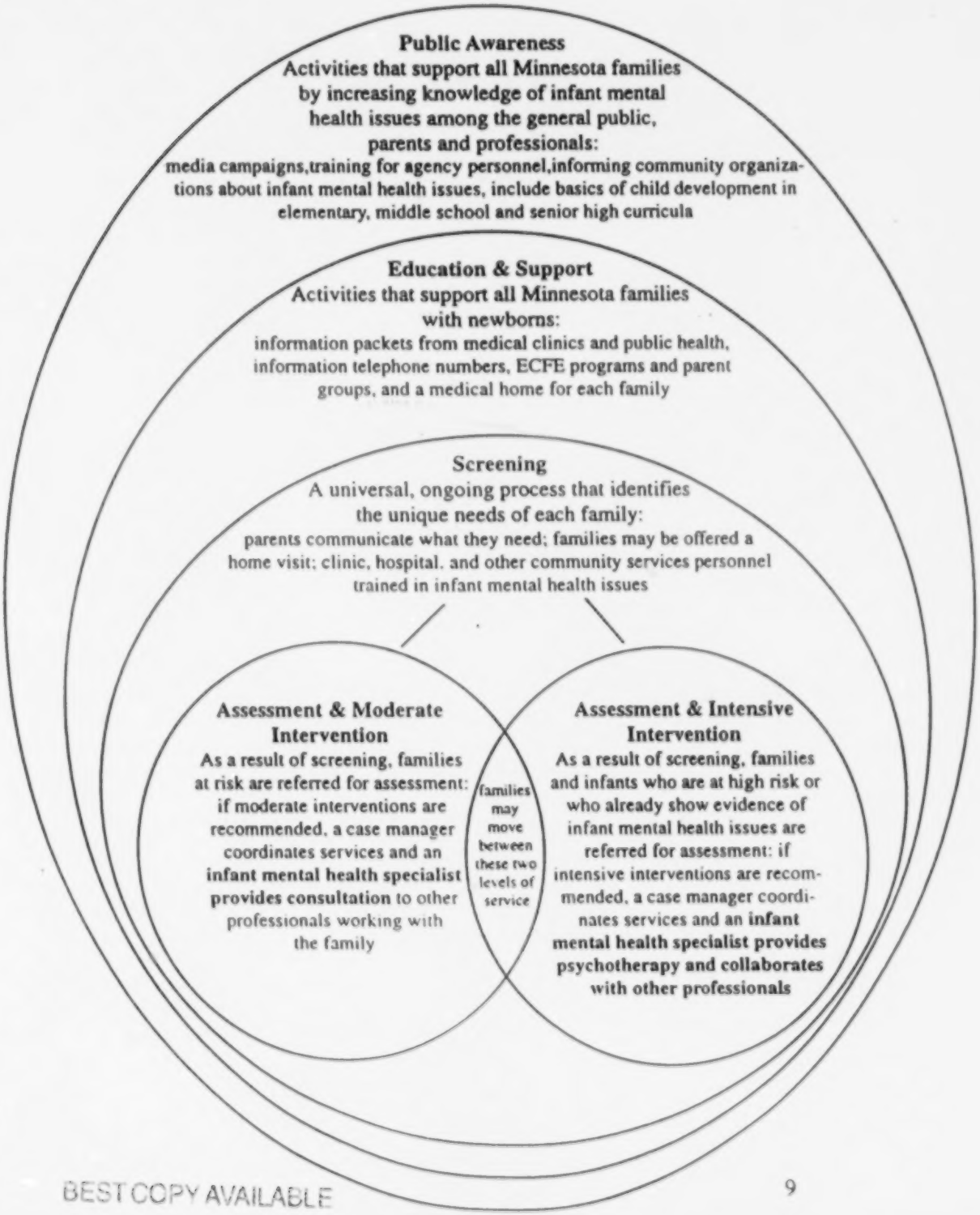
An examination of the early intervention literature (Dunst, Snyder, Mankinen, 1989) reveals that broad-based, **systems approaches** to early intervention are most likely to be responsive to, and meet the needs of, at-risk families. In addition, this study substantiated the finding that the most efficient process of service provision is **a needs-based approach** that bases services on the individualized needs of children and families.

The Consultant Team conceptualized infant mental health services within a multidimensional framework that would provide a coordinated and comprehensive "seamless" continuum of education and care for all infants and their parents utilizing prevention and intervention components. (See Diagram 1.) The concept of a seamless system is one that other states, such as Michigan, are investigating, as well (Tableman, 1997). The

mental health disorders are traumatic stress disorder, depression or other affective disorder, regulatory disorders, and disorders of relating and communicating.

Diagram 1

Conceptual Framework for a Coordinated System of Infant Mental Health Services


Public Awareness
Activities that support all Minnesota families by increasing knowledge of infant mental health issues among the general public, parents and professionals:
media campaigns,training for agency personnel,informing community organizations about infant mental health issues, include basics of child development in elementary, middle school and senior high curricula
Education & Support
Activities that support all Minnesota families with newborns:
information packets from medical clinics and public health, information telephone numbers, ECFE programs and parent groups, and a medical home for each family
Screening
A universal, ongoing process that identifies the unique needs of each family:
parents communicate what they need; families may be offered a home visit; clinic, hospital, and other community services personnel trained in infant mental health issues
Assessment & Moderate Intervention
As a result of screening, families at risk are referred for assessment: if moderate interventions are recommended, a case manager coordinates services and an infant mental health specialist provides consultation to other professionals working with the family
families may move between these two levels of service
Assessment & Intensive Intervention
As a result of screening, families and infants who are at high risk or who already show evidence of infant mental health issues are referred for assessment: if intensive interventions are recommended, a case manager coordinates services and an infant mental health specialist provides psychotherapy and collaborates with other professionals

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system would incorporate multiple features including: (1) the organization or reorganization of existing services and institutional systems in an effort to meet a family's basic survival needs such as food, housing, and health care; (2) the facilitation of a consistent, supportive relationship with the infant and parents; (3) a system of ongoing screening, assessment, intervention, and case management in order to address a range of developmental, mental health, and environmental or adjustment needs, and (4) the provision of intensive support and interventions to infants and their families experiencing more serious developmental and psychosocial vulnerabilities. (See Diagram 2.) The goal of services is to promote healthy infant-parent relationships, parental competence, and developmental progression in the infant. To do so, the model proposes integrating an infant mental health perspective into current services, creating new therapeutic infant mental health service options, and "coordinating the series of independently developed proactive efforts to provide early support and intervention to promote normal growth and development" (Tableman, 1997).

Guiding Principles

These guiding principles underlies the creation and coordination of infant mental health services. They form the foundation for the recommendations in this report.

1.) All infants and families will have community support that promotes the development of healthy families and children, including access to services that promote infant mental health at a level responsive to their needs.

2.) Infant mental health services will recognize that the optimal development of the infant and toddler occurs within the context of relationships—especially the relationship between parent and child.

3.) Infant mental health services will recognize the need to be sensitive to and to support parents so that they may in turn nurture their infants.

Diagram 2

How a Coordinated System of Infant/Toddler Mental Health Services Would Support Minnesota Children:

The Story of Three Families with Newborns

Public Awareness
activities that support all Minnesota families by increasing knowledge of infant mental issues among the general public, parents and professionals

Family A	Family B	Family C
	Education & Support	
	Screening	
family needs are met through Education & Support activities above	**Assessment & Moderate Intervention** as a result of screening, families at risk are referred for assessment: if moderate interventions are recommended:a case manager coordinates services and an **infant mental health specialist provides consultation** to other professionals working with the family	**Assessment & Intensive Intervention** as a result of screening, families and infants who are at high risk or who already show evidence of infant mental health issues are referred for assessment: if intensive interventions are recommended, a case manager coordinates services and an **infant mental health specialist provides psychotherapy and collaborates with other professionals**

4.) Infant mental health services will be based on a multidisciplinary perspective and practice that utilizes the expertise of many disciplines combined with principles of infant mental health. (Contributing perspectives include medicine, nursing, public health nursing, psychiatry, psychology, social work, education, child care, parent education, occupational therapy, physical therapy, and speech and language therapy.)

5.) All persons working with infants and their families must: know the stages of normal infant development; be able to recognize relationship and separation issues; and incorporate an approach that supports the parent-infant relationship into their practice.

6.) The legal and protective systems which interface with infants and toddlers will operate with well-informed policies and procedures that protect and optimize infant mental health needs. Professionals in the areas of child protection, guardians ad litem, judges, referees, attorneys, foster parents, and mental health personnel who are involved in court recommendations for very young children will have a thorough knowledge of infant mental health needs to inform their judgments and decisions. In addition, attorneys, referees, and judges who make custody and visitation recommendations will also create recommendations that enhance infant mental health.

Criteria for Effective Service Delivery

The following criteria, based on research and successful service delivery models already in existence, identify effective infant mental health services and reflect what the Consultant Team believes to be the crucial components of "effective practice" in the field of infant mental health.

1.) Infant mental health services will be based on the family's strengths as well as its needs.

2.) Service providers will strive to be both sensitive and responsive to the unique qualities, values and culture of each family and its community.

3.) Service providers will form collaborative relationships with families, listening and learning from each other as they all seek to provide what is best for the child.

4.) For families receiving services from multiple providers, infant mental health services will be provided by one of the providers (either an infant mental health specialist or a professional from another discipline) who will establish a significant relationship with the family, thereby forming and maintaining ongoing, consistent support to the family. In situations where infant mental health services are provided by another provider, the infant mental health specialist may act as consultant.

5.) For infants and families with multiple needs, a coordinated service plan will be developed to eliminate fragmentation and duplication of services.

6.) Infant mental health services will be provided in settings that are most accessible to families. In the case of infants and families with multiple needs, all services will be provided in one setting (home, school, child care, Head Start, etc.) determined in consultation with the family.

7.) Services often will be offered on a long-term, rather than time-limited, basis in order to foster, reinforce, and consolidate learning and changes toward the goal of infant mental health.

8.) To ensure the delivery of quality infant mental health services, professionals will have ongoing access to training and consultation.

9.) Professionals providing intensive infant mental health services will have sufficiently small caseloads to meet with the family at least once per week, and more often if the family is in crisis.

10.) Infant mental health services will be planned, developed, and provided within existing, effective service delivery systems.

Encourage the development of partnerships with community health centers; create money to be utilized for mental health consultation, outreach, and direct service (wraparound) so parents and children have access to mental health services.

—Survey Respondent

11.) The effectiveness and efficiency of infant mental health services will be determined on an ongoing basis. The results will be used to improve services.

RECOMMENDATIONS

The Minnesota Infant Mental Health Feasibility Study Consultant Team recommends that infant mental health services be identified and organized as a continuum of activities divided into five broad areas:

1.) public awareness
2.) education and support
3.) screening
4.) assessment and intervention
5.) training and consultation

A statewide public awareness campaign should be implemented, followed by targeted education and support activities for prospective new parents and parents of young children. Screening should be implemented on an ongoing basis to monitor for evolving child and family needs.

When the screening process identifies families that may need intervention services, assessment defines the nature and extent of services needed. Moderate intervention services are offered to families experiencing circumstances and vulnerabilities associated with risk to an infant's mental health. Intensive intervention is provided to families whose infants are at high risk or are already experiencing problems or disorders that may indicate impaired mental health.

A family's level of service may change over time. Responsive to the infant's unfolding development and the family's need, a family may move from one level to the next, particularly between moderate intervention and intensive intervention. Systems will need to be flexible to respond to a family's changing needs. To be so, they must exist within a coordinated framework that allows for transition between levels as necessary and appropriate.

A statewide Infant Mental Health Network should be created consisting of Regional Infant Mental Health Network Teams that meet regularly to coordinate efforts

There is a great need to educate people about mental health issues and to eliminate the stigma attached to mental health treatment. Barriers to providing infant mental health services (include) parents who don't understand that they have issues that need to be addressed and who don't understand the needs of their child...

—Program Administrator

across disciplines and agencies and organizations, plan for outreach activities, share resources, and participate in specialized training in order to address the training, consultation, and service delivery issues related to infant mental health.

I. Public Awareness

It is recommended that State agencies and local communities take a leadership role in increasing public awareness of infant mental health issues.

Informed parents, who are knowledgeable about infant development and the range of physical and emotional needs of young children, are best equipped to make good choices for their young children. They should be supported by people in all walks of life, including professionals who work with families, who know what is necessary to nurture children. We all must recognize the importance of the early relationship between parent and child in order to make informed decisions about everything from the family's daily schedule, to family leave and other workplace regulations, to public policy on health care, social services, education, child protection and corrections. Informed citizens should support each other in changing behaviors, regulations and policies that undermine infant mental health and family well-being.

Strategies

1. State agencies and communities should create broad-based efforts such as media campaigns and educational literature to enhance an overall awareness of issues relating to infant mental health.

2. All state and county agencies that serve families should provide staff training to increase awareness regarding infant mental health and relationship-based services at all levels in their organizations and in the community organizations and agencies with whom they work. Relationship-based services are characterized by their emphasis on forming and maintaining supportive relationships between people over time. For infant mental health providers this means that professionals are supported in their work with families (through consultation, technical assistance, and supervisory

support) so that they in turn can support the unfolding relationships between parents and infants. In the field of child care, as another example, relationship-based services promote an emphasis on continuity in care for young children.

An emphasis on the importance of supporting relationships between parents and their children should be infused in all aspects of inservice training for professionals who work with families. By taking a stand on this issue, each agency communicates the importance of infant mental health to all within its culture. This leadership role in turn makes an important contribution to local agency operations by giving local administrators the "go ahead" to make infant mental health and relationship-based service delivery a priority. This has an effect not only on the workers' relationships and services to families, but also on the way in which they themselves are supported in their work.

I started working in the late '60's in a rural area. <u>All</u> newborns were visited then. Even that is late. There was a nursing visit and at least one follow-up. At least we made sure that the family was aware of other resources. That has gone by the wayside. Now usually we are involved only when there is medical high risk. We've lost something.

—Public Health Administrator

Relationship-based services recognize and support the development of ongoing, supportive relationships among professionals and between professionals and family members. By fostering strong peer and mentoring relationships among professionals, agencies can model aspects of the alliance that is optimal between the professional and the parent. The parent who experiences sensitivity and support from the professional is better able to be sensitive and supportive of the developing child. This parallel process of professionals and parents both supporting and being supported is at the very core of infant mental health and is crucial to the success of infant mental health services.

3. State and local agencies should take a leadership role in informing community organizations about infant mental health, thereby garnering additional support to families that reinforces relationships and their importance. Community organizations, tribal councils, faith communities, and local businesses should all play a critical role in educating and advocating for families.

4. The educational system should prepare future parents by including the basics of child development and parenting in family life education courses in elementary, middle school and senior high school curricula.

II. EDUCATION AND SUPPORT

It is recommended that State agencies and local communities take a leadership role in providing education and support for families with infants and toddlers to foster the development of healthy parent/child relationships.

All new parents should have access to information about infants and toddlers that will aid them in establishing and maintaining healthy relationships with their children. In addition, primary care physicians and emergency room staff, as well as WIC staff and other social service providers, should provide information to families. Due to increased mobility and other changes in our society, we need to develop creative, alternative ways of providing support to new parents. These new sources provide information, consultation with experienced and knowledgeable people, and links to other new parents—things that used to be more readily available through informal means such as extended family and close relationships with neighbors and other community members.

All aspects of service delivery should recognize and incorporate knowledge of the variety of cultural traditions represented by Minnesota families, including recent immigrants who may have very divergent parenting philosophies and practices. An approach that respects culture builds relationships with families on a foundation of attitudes, values and behavioral expectations of the home culture of the child. Continuity, consistency, and respect for cultural foundations are essential to children's continuing growth.

I think that there is a real problem that is getting worse with the financial restraints of health care...the real bind of needing to see more patients and getting paid less for it ...and I think we deal more and more with crisis issues. A well child checkup should be 80-90% about anticipatory guidance and dealing with the behavioral and emotional issues of children and families... I don't know that pediatricians have time to do that or even have the skills to do that. I see a big need for more resources.

—Pediatrician

Strategies

1. At critical intervals during their child's first three years, all new parents should receive a packet from their medical clinic or public health agency that includes information about infant/toddler mental health, in addition to other aspects of parenting. The packets should include information on developmental milestones and

guidance, as well as information on resources in the community (agencies, support groups, etc.). Examples of other specific types of information that parents should receive include the importance of continuity in substitute caregivers, what to look for in child care, and how to handle separations.

2. The Minnesota central early intervention information telephone number[5] should be supplemented to include information about infant mental health.

3. Individual communities should establish a local telephone number offering infant mental health information along with parenting assistance. This information number could exist within the services of any of a number of agencies or organizations.

4. The statewide Early Childhood and Family Education (ECFE) should be expanded to include infant mental health as a primary focus. ECFE could play an important part in delivering preventative and educational services.

5. Parent groups for all parents, including specialized groups for parents with children with special needs, should be available in all Minnesota communities to support parents through the prenatal period and following the birth of their child, providing another opportunity for parents to receive information on child development and anticipatory guidance, and to meet and network with other families with young children. In our rapidly changing, mobile society more formalized systems of support are needed as a replacement for the informal supports of extended family, neighborhoods, and communities that were in place in the past.

6. Policies should be changed to insure that each Minnesota family has a stable "medical home," in which the child receives ongoing health care and guidance. The medical home offers continuity of care from a physician—and from other professionals including infant mental health specialists. The medical home insures that the

Make sure that all early childhood specialists, ECFE staff, pediatricians, etc., have access to telephone numbers needed. Anything that they can have in their offices or classrooms would be helpful. Parents can take these numbers and "go with them."

—Parent

[5] The Minnesota central early intervention information telephone number is 1-800-728-5420 or 623-5150 in the Twin Cities Metropolitan Area.

infant mental health provider will not change when the family moves between levels of service or between service providers. All Minnesota children should be covered by health insurance to guarantee that they have access to preventative care.

7. **All Minnesota families should have access to high quality, affordable child care, including families leaving the welfare rolls to enter the workplace. Parents must receive information on how to determine quality in child care and must then be able to access that care.**

8. The State should consider incentives for government and corporate offices to create policies that foster stronger families and increase infant mental health (for example, on-site child care, extended family leave, etc.).

The reality is that mental health issues for infants may be identified in many different places. They should be. They're often not, but they should be identified in many different places. The notion that there could be a single entry point for services is somewhat misguided.

—Hospital Psychologist

III. SCREENING

A. It is recommended that Minnesota provide universal screening for newborns and their parents to identify families that need services.

Universal screening would increase our ability to strengthen the social, emotional, cognitive and physical well-being of infants within secure and stable caregiving relationships. This screening should focus on all the important pieces that must be in place to nurture the infant—not just the medical needs, but everything from housing and nutrition to secure relationships within the family and between infant and parent. By reaching all families early on, we should identify and mediate a variety of issues that could prove to be harmful if left undetected until the child is older. The period of time close to the birth of a child is when families are most focused on the child and are most open to assistance. By employing universal screening we could avoid many of the problems associated with parents who become isolated after the birth of their child. For instance, the results of this study indicate that currently there are a number of services in place for teen parents. Fewer programs address the needs of young mothers over the age of 18, some of whom may become isolated once they return home from the hospital with their newborn. According to participants in our focus groups, many of these parents do not receive

services now, but may be most in need of them. Barriers such as transportation or maternal depression prevent them from participating.

It is critical that the screening process address the interplay between child and family issues in addition to the community and culture within which the family exists. Screening, and resulting assessment and intervention if necessary, are often best provided in the family's home where the parent and professional can address the infant's progress in that context. Any needs that are identified during interaction with families should be addressed with the type and level of service appropriate to the need.

I think that parents, especially mothers, feel guilt. The major issue of women who walk into this unit is that they think that they should have been able to do something differently to protect their baby during the pregnancy—even though they are told by many health professionals that that is not the case. My goal is to see that I help them resolve that issue.

—Social Worker, Hospital Neonatal Intensive Care Unit

Strategies

1. All new parents should be given an opportunity (written or verbal) to communicate what information and support they need and want. All personnel who see parents in the prenatal period (obstetricians, nurses, etc.) should use a simple checklist of needs to insure that parents have adequate and appropriate support.

2. All clinic and hospital personnel (nurses, physicians, social workers, and public health nurses) and staff in other agencies who are in contact with prospective and new parents should be trained in fundamental infant mental health issues so that they can be alert to the needs of the parents and child.

3. Communities should utilize a screening tool or tools that fit within their unique service systems.[6] Some communities may construct a "single point of entry" into the system by implementing universal screening of infants at hospitals immediately following birth or through a universal home visiting program. Most communities should consider "multiple points of entry" into screening, assessment and services. This allows professionals the flexibility to interact with families in the environment that is most accessible and/or most

[6] The BIA (Borgess Interaction Assessment) was developed in Michigan to be used as a screening tool by nurses at the hospital following the birth of the child. Other screening tools include the HOME (Home Observation for Measurement of the Environment), NCAF (Nursing Child Assessment Feeding Scale), NCAT (Nursing Child Assessment Teaching Scale), NBAS (Neonatal Behavioral Assessment Scale), and the Ainsworth Strange Situation.

comfortable for the family. It recognizes the diversity of families' cultures and, by ensuring that service providers in all fields are aware of infant mental health issues, screening becomes an ongoing process throughout early childhood.

B. It is recommended that screening be conceptualized as an ongoing, multidisciplinary, developmental process that begins in the prenatal period and extends through the preschool years.

The rapid, ever changing growth process from infancy through toddlerhood and on into the preschool years offers us opportunities to meet parents' needs at various points of change. Continual linking to parents during transitions can create a pattern of providing services across the years, as needed. This perspective recognizes that many situations and developmental changes may interrupt or compromise the family's well-being and impact their child's developmental progression. These situations may require either long-term support or intermittent, time-limited support to the family. In high risk situations, initiating interventions during pregnancy is most effective.

People who are so overwhelmed with concerns about the physical well-being of infants don't take the time to think about mental issues. It is my belief that within the medical setting the developmental needs of infants are not consistently and adequately taken into account in determining medical treatment. The other thing that isn't taken into account is how overall family mental health affects infants. We have an inadequate system to assess and respond to family needs.

—Hospital Psychologist

Strategy

Ongoing screening should be in place within the practices of pediatric and family practice physicians, as well as within the range of community-based services including, infant child care, social services, and public health. Screening would be constructed in a flexible manner in order to allow for its easy incorporation into preexisting community-based services.

IV. Assessment and Intervention

A. It is recommended that communities establish procedures for assessment of the parent/child dyad to establish needs and to guide referrals.

Strategies

1. Each community should develop an assessment process based on up-to-date methodology that would

combine formal assessment and clinical observation.[7] Good assessment tools assess capacities, document problems, allow the formulation of planful interventions, and measure progress. They document the present and point toward the future. Ongoing assessment is used to monitor the progress of intervention and inform adjustments to the intervention plan. The unfolding capacities of both the parent and the child, within the context of their environment, should be assessed on an ongoing basis. Those working with the family continue the assessment process, through both formal and informal means, during each interaction with the family. This continuing assessment process allows the professional and the parent to focus on the developing relationship between parent and child.

2. The State should provide technical assistance to communities in the establishment of the assessment procedures.

B. It is recommended that moderate level intervention be available in all Minnesota communities to support families experiencing circumstances and vulnerabilities associated with risk to an infant's mental health. Infant mental health specialists, who have received clinical training in this specialty, should be available for consultation to those who deliver services at this level, and for direct service to families, whenever necessary. The family's home will be the optimal place for service provision for many families.

...from our first inklings that something was wrong to actually getting our son into services was a long time...a full assessment by a team of people who looked at overall growth and development supplied me with written documentation. Once he was assessed, all doors opened.

—Parent

Strategies

1. Many issues—financial, emotional, developmental, and practical—can cause stress to the family and risk to the infant. The infant mental health specialist should be available to assist with this range of issues. And, in fact, by providing "concrete" assistance such as access to clothing,

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[7] Assessment instruments, such as the Denver and Bayley, are used to determine developmental delay. As Charles Zeanah notes, research on infant psychopathology is a relatively new field. Limitations of this new research include the "absence of significant efforts to validate any of the significant disorders that have been described" and "lack of uniformity in the criteria used to define disorders..." Zeanah goes on to say, "For this reason the recent emergence of the Diagnostic Classification: 0 to Three (Zero to Three, 1994) system is a welcome starting point." (Zeanah, 1997).

food, or transportation, the work of the infant mental health specialist is enhanced. The demonstration of support in other realms contributes to building a firm relationship with the family, and reinforces the psychotherapeutic role of the professional.

2. A "case manager" or "service assistant" should be identified for each family receiving moderate or intensive services to coordinate these services.

We have a lot of pressure to place kids in special education due to adjustment problems that would be better treated by mental health professionals.

—Survey Respondent

Some families will be receiving multiple services for their child that could include occupational therapy, physical therapy, and home health care. Case management reduces fragmentation and duplication of services. The case manager can be from any one of a number of fields, based on the situation and the needs of the family (for instance, if the child has health problems, the public health nurse may serve as the case manager). The case manager identifies when temporary or intensified services are necessary. The person identified as case manager must receive time and compensation for fulfilling this role. One of the crucial responsibilities of the case manager is to insure continuity of the relationship between the family and service provider. Continuity may come from the case manager, or from an infant mental health specialist or other professional who should establish and maintain an ongoing relationship with the family, no matter how the needs of the family may fluctuate.

3. Center-based services, including parent groups, should be available in all communities.

These programs, operated by community health, ECFE, high schools, or community organizations, provide important infant mental health services. They facilitate relationships between parents that in turn support parent/child relationships. Support groups centered on a specific issue, such as autism, assist families who are under stress and need both information and connections with others who are undergoing similar experiences.

4. The IEIC[8] in each community could serve as the conduit for connecting with infant mental health specialists for consultation and direct service to families.

Professionals in all disciplines should have access to consultation with an infant mental health specialist in their community and to request direct intervention by the specialist whenever necessary. The specialists themselves can be from a variety of disciplines, but must have specific and in-depth training in infant mental health and relationship-based intervention. Peer consultation is important in the process of delivering infant mental health services. Specialists must have the opportunity to consult amongst themselves on a regular basis.

C. It is recommended that intensive intervention be provided to Minnesota families whose infants are at high risk or who already are experiencing problems or disorders that may indicate impaired mental health.

Strategies

1. A coordinated selection of interventions based on family needs should be created to offer families whose infants show evidence of infant mental health issues.

2. A collaborative service plan, developed in concert with the family, should guide service delivery and provide for effective, consistent services based on an ongoing relationship between the family and the infant mental health specialist. A goal is to reduce the number of professionals entering the home. In some cases the infant mental health specialist may provide case management in addition to psychotherapy. In other instances, a case manager may have already established a relationship with the family and it would be best to continue that relationship.

3. The infant mental health specialist provides infant-parent psychotherapy in the home, unless another therapy setting is considered optimal. This therapeutic intervention is paired with parent education, parent

Within our mental health agency it took determined people to advocate (for the importance of infant mental health services) because of the many other competing interests. However, I believe that if these services were more widely available we could get rid of our junior high day treatment program.

—Focus Group Participant

[8] IEIC's (Interagency Early Intervention Committees) are the local structures through which Part C Federal Special Education funds are disbursed for the birth to age three population. Part C supports training of personnel and service coordination, but not direct service provision.

support groups, child care, and other interventions as needed to foster and support a healthy parent/child relationship.

4. In some situations, parent-specific services such as individual psychotherapy for the parent and chemical dependency treatment may be paired with infant/parent psychotherapy.

5. As families receiving intensive services stabilize, they should be connected to community supports, including parent education activities and support groups, as appropriate.

IV. Infant Mental Health Network

It is recommended that state agencies in Minnesota collaborate on developing and maintaining an Infant Mental Health Network of specialists throughout the state.

There is a great need for stable funding sources and commitment to maintenance of a program, not just start-up money for innovation.

—Therapist and Program Manager

By blending funding from a variety of sources, state agencies, in collaboration with the University of Minnesota and other institutions of higher education, should take a leadership role in establishing a network of professionals from various fields who are committed to infant mental health work and willing to be trained and become available to communities throughout the state. These Network participants would provide direct service, training, collaboration and consultation to existing organizations and agencies (See Diagram 3). In addition, state agencies should facilitate the creation of several types of advanced training in infant mental health, including some connected to institutions of higher education.

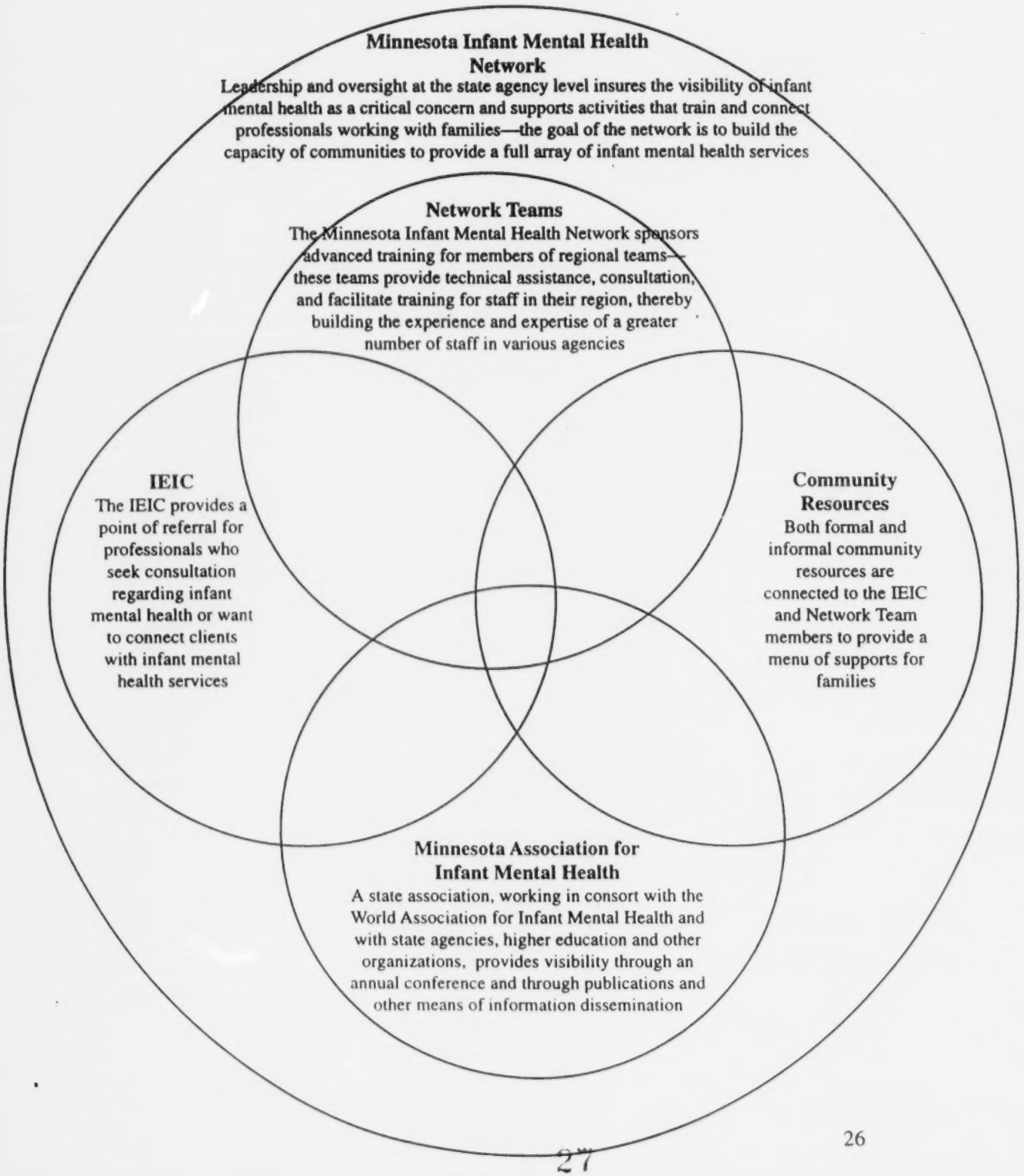
Strategies

A. The State should blend funding streams and contract with local communities to support infant mental health specialists. Local communities should come together to develop their own system of services centered around the expertise of an infant mental health specialist and other involved professionals.

B. Interagency Early Intervention Committees (IEIC's) provide a structure that can be used to organize mental

Diagram 3

How a Community Might Coordinate Infant Mental Health Services with Support from a Minnesota Infant Mental Health Network


Minnesota Infant Mental Health Network
Leadership and oversight at the state agency level insures the visibility of infant mental health as a critical concern and supports activities that train and connect professionals working with families—the goal of the network is to build the capacity of communities to provide a full array of infant mental health services
Network Teams
The Minnesota Infant Mental Health Network sponsors advanced training for members of regional teams—these teams provide technical assistance, consultation, and facilitate training for staff in their region, thereby building the experience and expertise of a greater number of staff in various agencies
IEIC
The IEIC provides a point of referral for professionals who seek consultation regarding infant mental health or want to connect clients with infant mental health services
Community Resources
Both formal and informal community resources are connected to the IEIC and Network Team members to provide a menu of supports for families
Minnesota Association for Infant Mental Health
A state association, working in consort with the World Association for Infant Mental Health and with state agencies, higher education and other organizations, provides visibility through an annual conference and through publications and other means of information dissemination

health services for families with infants and toddlers. Each Minnesota community has established its own unique IEIC to coordinate services for children birth to three years of age. To establish a comprehensive screening and service delivery network for infant mental health services, communities should assess what representation they have on their local IEIC and strive to include child care representatives, Early Head Start personnel, mental health workers, public health nurses, medical personnel (including staff from prenatal clinics, hospital neonatal intensive care personnel, and family practice physicians and pediatricians), social workers, those who work in the area of chemical dependency, and representatives from child protection and corrections. All of the above need to be invited to participate at some level, if only to receive regular communications about infant mental health activities and issues. Broad-based involvement will insure "buy in" to the concepts of infant mental health and relationship-based services so that systems operate in the best interests of infants and their families.

C. The State should develop an Infant Mental Health Network (modeled, in part, on the Minnesota Autism Network). The research done for this study shows that there is a need for local expertise in communities across the state. Regional Infant Mental Health Network Teams, consisting of infant mental health specialists and other interested professionals, would meet regularly to plan for outreach activities, share resources and participate in specialized training based upon current research. The Teams then would provide services in their districts and regions, depending upon families' and systems' needs.

The system of training in infant mental health should mirror the levels and functions of services:

1.) Awareness trainings should be developed for parents and for all those who work with families.

2.) Education and support training should be offered to those who have a more involved relationship with families, including medical personnel, home visitors from various agencies and ECFE staff. Continuing Education Units (CEU's) could be offered to professionals who participate in infant mental health training.

3.) Training in screening should be a part of the personnel preparation for a number of job positions in a variety of fields, including for medical personnel, ECFE staff, and early childhood educators. Training is needed in informal screening (observation) as well as in formal screening tools.

4.) Infant mental health specialists require postgraduate clinical training specific to assessment and intervention with infants and their families.

A mainstay of the specialized training provided in infant mental health should be a cross-systems training series of one half day or full day trainings spread over the course of the year. These trainings would require a long-term commitment from participants and their agencies so that continuity of instruction would be guaranteed.

D. The State could act as a key resource in supporting ongoing consultation for infant mental health specialists by funding and coordinating consultation services throughout the state.

E. Minnesota is the home of internationally-recognized experts in the field of early childhood research, specifically attachment theory and early brain research. By working in collaboration with existing resources such as the Irving B. Harris Training Center for Infant/Toddler Development and CEED, the Center for Early Education and Development, at the University of Minnesota, the State should facilitate the development of several types of graduate level training in infant mental health. (See Diagram 4.) These training programs could include the following:

1.) A graduate certificate program tied to masters degree work—This training program would prepare professionals in a variety of graduate degree programs to serve their communities as infant mental specialists.

2.) A post-masters degree certificate training program—This program would be geared toward professional development, perhaps held on weekends so as to accommodate the work schedules of participants.

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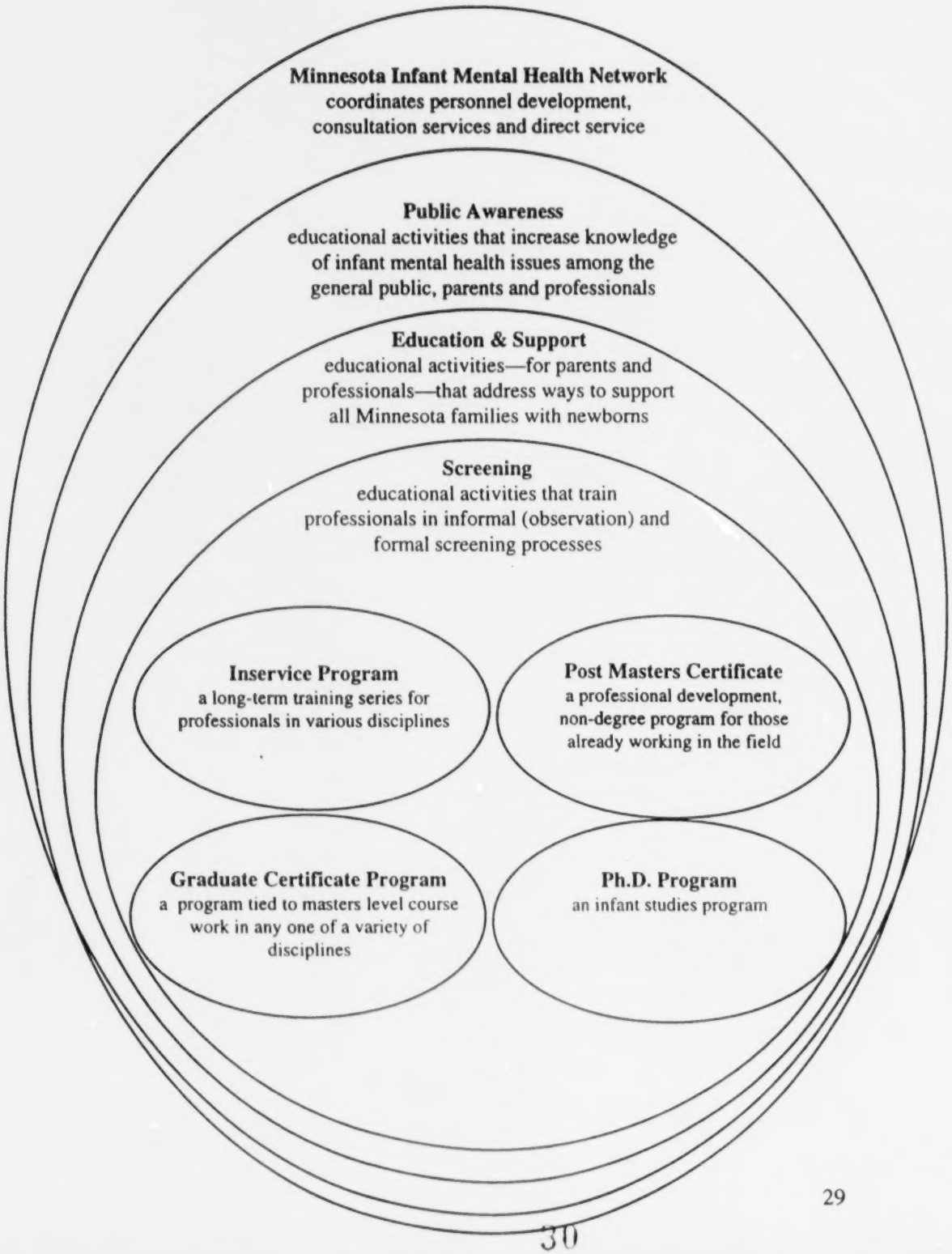
Diagram 4

Conceptual Framework for a Coordinated Training System for Infant Mental Health Services


Minnesota Infant Mental Health Network
coordinates personnel development, consultation services and direct service
Public Awareness
educational activities that increase knowledge of infant mental health issues among the general public, parents and professionals
Education & Support
educational activities—for parents and professionals—that address ways to support all Minnesota families with newborns
Screening
educational activities that train professionals in informal (observation) and formal screening processes
Inservice Program
a long-term training series for professionals in various disciplines
Post Masters Certificate
a professional development, non-degree program for those already working in the field
Graduate Certificate Program
a program tied to masters level course work in any one of a variety of disciplines
Ph.D. Program
an infant studies program

3.) An infant studies graduate degree geared toward a Ph.D.

F. The State should facilitate the revitalization of the Minnesota Association for Infant Mental Health, a chapter of the World Association for Infant Mental Health. A state association can bring professionals from many disciplines together at conferences for the sharing of information and could publish materials related to infant mental health for distribution among its members and other interested parties. The Association could play a significant role in advocating for an infant mental health perspective in all work with young families and for keeping professionals up-to-date with current knowledge and skills in the field. The Michigan Association for Infant Mental Health is an example of a dynamic state association.

Costs and Cost Savings Related to Infant Mental Health Services

The effects of attachment disorders, inappropriate parenting, and developmental delays in infancy are related to other childhood risks and can lead to a host of further costly problems in the child's adult life (Tableman, 1995). Experience in Michigan infant mental health programs and evaluations of programs elsewhere indicate that infant mental health services can reduce health care costs by:

- reducing the prenatal and delivery costs for additional births through connecting mothers to and promoting the use of family planning services

- reducing the costs of medical care related to inorganic failure to thrive

- reducing the use of emergency rooms for non-emergency health care

- reducing the costs of preventable illness care by facilitating immunization

- reducing the costs of medical care related to respiratory infections, poisonings, and accidental injuries

- reducing the costs of medical care for intentional injuries resulting from child abuse

- reducing the cost of outpatient and inpatient mental health services incident to mothers' stress, depression, isolation, and familial conflict

- reducing the cost of developmental delay and need for mental health services for the child

In 1995, the Michigan Department of Community Health estimated that, based on actual case incidence, the maximum cost of providing what this study refers to as "intensive" infant mental health services to 100 families by five infant mental health specialists would be between $250,000 and $325,000. For those 100 families, it was estimated that the savings (medical costs avoided less cost of providing infant mental health services) would be from $134,00 to $59,000. These savings do not account for additional cost savings from school completion, movement off AFDC, reduction in the use of special education, and subsequent criminality and mental health treatment for the child as he or she becomes an adult.

From a public policy point of view, the short-sighted emphasis on tax reduction and cost control, as opposed to investment in the well-being of infants, has a huge effect on providing needed services.

—Hospital Psychologist

Policy and Program Implications

Research findings, coupled with both the statistical and experiential evidence collected for this study, clearly call for serious examination of our social system and how it supports parenting. The vulnerabilities of both parents and babies—and their resiliency in the face of the many threats to their developing relationships—lead us to some profound program and policy issues. The problems are complex and are intertwined with cultural values and economic pressures that further complicate the possible remedies. We propose the following for consideration when it comes to programs and policies that affect young children and their families.

Education for all citizens, young and old, on child development and related topics should be infused in many learning environments. Schools, religious organizations, and youth groups can contribute to preparing young people for parenting by offering this information through their programs.

Promote responsible parenthood through expanding proven parent education/support programs.

Home visiting as a service strategy should be carefully analyzed in view of recent research that recommends its use with targeted populations. Home visiting can be a powerful tool in screening for infant mental health issues and is usually the preferred mode for infant mental health intervention services.

Workplace policies that strengthen parent-child relationships should be supported.

Changes in laws that impact families, such as the recent welfare-to-work legislation, should reflect consideration of infant mental health.

Expectant and new parents and their young children must have access to preventive and primary health care coverage.

Intervention at the earliest stages, when needed, will insure the best outcomes for families.

Improve the quality of child care so that children can thrive while being cared for outside their homes.

Informal, community-based supports (churches, youth centers, etc.) should be considered as important resources in the fabric of inter-related services.

Basic knowledge of infant/toddler mental health must inform the decision making process in foster care, child custody disputes and adoption.

Agencies and organizations that provide services must provide reasonable caseloads and time to do the work that must be done to support families.

Our knowledge of infant mental health provides strong reasons for working to coordinate services within our systems to insure continuity of relationships between families and professionals (in medical, mental health, and allied professions).

We must ask the questions: "Is the environment appropriate to meeting the infants' needs? Are we giving 'emotionally' quality care? How do we know?" Some days you question what the infants' experience is. "What family life do (these infants) have with so much daycare?" We don't really know yet how such extended daycare will affect children in the long run.

—Infant Caregiver Working in a Child Care Center

Programs that provide services must build in a means of collecting longitudinal outcome data in order to document program costs and effectiveness.

The institutional and community-based infrastructure serving children and families should be organized around common themes and goals so that services are integrated and coordinated across agency and discipline lines.

Many of our state laws are written to protect parents' rights. Our knowledge of infant mental health makes it imperative to balance our regard for parents with the emotional needs of children.

Methodology

This study was conducted in eight steps, as follows:

1. Literature Review—Research and information about service delivery systems on the topic of infant mental health were reviewed, with particular attention as to how infant mental health has been defined, how various systems have provided services, and what interventions have been successful.

2. Other State Models—Literature from other statewide efforts was reviewed, particularly states with a history of addressing infant mental health services.

3. Paper Survey—A survey was conducted by mail, using lists from a variety of disciplines, to determine the range of services available in counties throughout Minnesota. The survey identified communities that have well-developed service systems in place, as well as those that have very few resources.

4. Interviews with Service Providers and those in Key Positions—Personal and small group interviews were conducted with individuals who are playing key roles in infant mental health now and those who have a major role in defining future developments in the field. The interviews represent a range of viewpoints including those of providers, educators, administrators and parents.

5. Regional Focus Groups—Five focus groups were conducted with Interagency Early Education Committees

(IEIC's) in different regions of Minnesota (chosen through analysis of survey data so a variety of circumstances would be represented) to learn about their service systems. Some regions might serve as models for other communities. Others assisted defining the challenges presented in communities where few resources have been developed.

6. Out-of-State Consultants—Consultation meetings were held with out-of-state experts from Michigan (a state with a long-standing mental health service systems for infants and families) who provided consultation regarding the development of a Minnesota plan for infant mental health services.

7. Preliminary Feedback—Reactions to a draft report were elicited from an Advisory Committee to provide outside perspective.

8. Statewide Work Group—Final feedback from the statewide Infant Mental Health Work Group (an ongoing group convened by the State Early Intervention Team that has been working on the topic of infant mental health since 1993) was elicited. The input was used to make revisions in the recommendations prior to submitting the competed report to the Minnesota Early Intervention Team.

It seems that now services may be available to families at risk of abuse or with an identified special education delay. Too many families don't fit into either mold and so are denied access to these services. Also, many insurance plans don't cover mental health services. Families can't afford them out-of-pocket and yet don't meet the financial criteria for funding assistance.

—Survey Respondent

Minnesota Needs Assessment

One of the primary goals of this study has been to ascertain both the need for infant mental health services in Minnesota communities, and to determine the current level and type of services available to families. In the surveys, interviews, and focus groups that were part of this study, professionals and parents voiced concerns about a whole range of needs. Some told stories about barriers that make it difficult for families with infants who have identifiable concerns to get appropriate services quickly—before problems intensify and become less amenable to intervention. Professionals spoke about the many families at risk in their communities and the young children they predict will end up—many needlessly— in special education and behavioral programs once they reach school age because they and their families did not

receive support early on when children are establishing their first relationships.

The results of the mail-in surveys and focus groups conducted by this study are detailed in the attached appendices. In addition, "County Profiles" were compiled from all the survey responses from each county. The profiles (which are available upon request) give a "snapshot" of each community for examination and offer the opportunity of comparing and contrasting needs and services in Minnesota counties.

A focus on the importance of infant development in the context of relationships has been a significant trend in recent research and clinical work with families. This perspective maintains that the healthy development of an infant is dependent upon the parent/child relationship, as well as the relationships between other family members and those between people in the child's community. This idea of interlocking connections between people in their support of childhood carries forward into the relationships between parents and professionals who intervene with families and among the professionals themselves. The implications of this way of viewing child development are broad and reach deeply into the way we support parents and young children. They force us to reexamine both what we offer families in the way of support and how we offer that support.

Infant Mental Health Activities in Other States

Most states that have approached the issue of infant/toddler mental health, such as Arizona and Ohio, are in the beginning stages of developing a systematic approach to providing services. Hawaii has developed a program targeted toward the prevention of child abuse and neglect that has been widely replicated in other states, including Minnesota. Michigan has a rich tradition of training and service delivery based in Selma Fraiberg's pioneering work with infants and parents.

Systems that were reviewed, within and outside of Minnesota, initiate services from the prenatal period, at birth, or very closely following birth. These early contacts assess for risk to identify the most needful and vulnerable infants and families. Early and ongoing assessments of

risk and need are used to formulate intervention goals and treatment plans.

Through the review of infant mental health service models in other states, questions and issues were identified that had to be considered in the development of a Minnesota model. Created as a program to prevent child abuse and neglect, the Hawaii model, by design, targets the families at high risk for abuse and neglect. The Michigan model targets infants "at risk for poor psychosocial, cognitive and behavioral outcomes" to receive services. Early in the process of examining these issues, the Consultant Team came to the consensus that intervention for vulnerable families should be set within a context of serving all Minnesota families with newborns.

Other issues raised by systems in other states include: whether to use professionals or paraprofessionals in service delivery; whether home visiting, office-based, or center-based programs (or a combination of these) provide the best services; and how to decide issues of frequency, intensity, and duration of services. The recommendations address some of these questions. Others deserve further study and thought, with the understanding that **flexibility of service delivery** is one of the most desired qualities identified by the practitioners and parents that were contacted during the course of this study.

Conclusion

The mental health of infants and toddlers, established and maintained by nurturing environments and interactions with their primary caregivers, is of crucial importance to all of us. It sets the stage for children to learn and to succeed in life. Infant mental health services play a large role in addressing the changing needs and circumstances under which families are raising their children in today's world. The needs of families are very real, and the manner in which we meet them will contribute to the future of our society. In a very basic way, infant mental and physical health is the foundation of each new generation. A coordinated system of services to support good health—physical and mental—will help insure that this foundation is solid.

Minnesota has a rich tapestry of services for children and families that can, if coordinated within the framework of a statewide service system, provide much of the form and substance required for quality infant mental health services. The recommendations in this report propose to guarantee that Minnesota parents have the education and support needed to be successful— and that when parents and families have problems, there will be services in place and accessible to them so that their children can be raised in a nurturing environment with caring, responsive caregivers.

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Appendix A

Statewide Survey Results

One of the primary goals of the study was to gather information about the existing services in Minnesota related to infant and toddler mental health, as well as to determine what practitioners across the state feel are the greatest service needs regarding infant mental health. To this end, 334 paper surveys were mailed to those listed on what were determined to be four key groups of individuals: Public Health Nurse Directors, Family Service Collaboratives, Maternal and Child Health Coordinators, Interagency Early Intervention Committee (IEIC) Chairs, and Minnesota Department of Health Home Visiting Projects. Of those mailed out, 41% (137) completed survey forms were returned. Another 8% (26) were returned but not completed. Many communities, both rural and urban, are reflected in the survey results. Responses came from representatives of 84% (73) of Minnesota's 87 counties.

The survey was constructed to glean information about services directly tied to infant mental health, such as screening newborns and their caregivers for potential needs and home visiting, as well as services that may not immediately come to mind in relationship to this topic, but which, in fact, do have a great impact because they involve issues that are considered "risk factors" with regard to infant mental health. These include infants or toddlers with developmental delays, infants who experience trauma, parents who are experiencing extreme relationship or marital conflict, and parents who have emotional problems or mental retardation. The Consultant Team created an exhaustive list of factors and asked survey respondents to respond to questions about services geared toward the child and about services geared toward the parents. The goal was to gather information about both the breadth and the depth of services available in Minnesota communities.

Following is a summary of the responses to the survey questions. Because many services are organized and implemented at the county level, county profiles were created from the returned surveys. Where there was more than one survey returned from a county, the survey responses were compiled into one profile for that county. This approach offered a clearer picture of what services are available throughout the state and also served to focus in on the finer details of what is happening county by county. The numbers indicate the number of types responses with one counted for each county, even in cases where more than one survey was returned from a county.

1a. Is there a process for screening and assessing newborns and their parents for potential developmental or parenting problems?

Yes: 94% No: 5% No Response: 1% Total Number of Responses: 68

The majority indicated that there is a process for screening and assessing newborns and their parents for potential developmental and parenting problems.

1b. If so, what professionals provide screening and/or intervention at birth and through what program?

A wide variety of professionals were reported to provide screening and intervention at birth and during the early childhood period. Public health nurses were the professionals cited most often. Screening and intervention services were provided through a range programs including home visiting (encompassing prenatal risk assessment, postpartum and newborn visits), Follow Along and Baby Tracks, CTC screening, MCH, Healthy Beginnings, CTF Family Enrichment Project, Adolescent Parenting, HUG (Helping Us Grow), and universal contact. Local physicians and nurses were other professionals commonly reported, as were health, education and human services professionals involved in County Collaboratives, IEIC, and Early Intervention services. Screening programs implemented in the hospital and/or clinic setting included checking newborns and documenting risk factors and interactions between the newborn and parent (to make referrals to public health and other agencies if needed for follow-up), CTC, well-child exams, and EPSDT. Programs associated with the collaboratives, IEIC, EI, and included Central Referral Team, First Step Team, Interagency Assessment Team, PACT 4 Families, Healthy Start, and Parents as Teachers. In addition, ECSE and ECFE staff, including teachers, speech therapists, psychologists, and physical therapists offered screening and intervention services often through school systems. Social services were also said to provide services as was the Minnesota Department of Health, which provided birth certificate follow up and referral. Other programs provided by a variety of professionals included Partners in Parenting, Community Support Program for Young Children, Planned Parenthood, County Extension Service, Healthy Families America, 348-TOTS, WIC, Early Help Program, Infant Monitoring Program and Head Start.

2a. Is every newborn in your community or county visited at home shortly after birth?

All Are Visited: 38% Some Are Visited: 60% Don't know: 2%

Total Number of Responses: 68

"All" indicates that there is a universal offer of a home visit. "Some" indicates that offers for a home visit are made to selected families, based on referrals tied to risk factors or requests made from parents or professionals in contact with the families, such as physicians or nurses.

2b. If so, by whom and for what stated purpose?

The majority of respondents indicated that home visits are conducted by public health nurses. Other home visitors include: ECFE staff, ECSE staff, WIC staff, paraprofessionals, and a variety of professionals from HMO's and private home health care agencies.

2c. Does this visit involve observing the parent(s) and child together?

Yes: 94% Don't Know: 2% No Response: 2% Not Applicable: 2%
Total Number of Responses: 63

The majority of respondents indicated that the home visit involves observing the parent(s) and child together. Interactions between parent and child, health, and family systems are central areas looked at by visitors. The interactions between the parent or family and the infant includes observing bonding and attachment, feeding, and comforting techniques. Also, physical and verbal interactions are noted, such as evidence of touch, parental response to infant cues (and the infant's response to cues from the parent), and parental perceptions and interpretations of the infant and his/her actions. Health of the infant is assessed and may include head-to-toe physical assessment, charting of growth and development, and gathering information about medical and nutritional needs. If applicable, further information about newborn and/or postnatal complications is gathered. Looking at the infant and family system can include observing the home environment, living situation, family dynamics, potential safety issues, and support systems. In many counties the above observations are used to determine whether the family meets risk criteria and/or needs additional support or referral to other agencies.

2d. If so, is there anything in particular that the visitor looks for? Is any sort of checklist or observation tool used?

Many counties reported that they are using or are currently developing some type of checklist or observational tool. The types of checklists and observation tools in use varies widely. NCAST, Denver II, and newborn and postpartum assessments are the tools reported most frequently. Others stated that they use no formal tool, but that observation is utilized.

2e. Are visitors trained?

Yes: 87% Don't Know: 6% No Response: 7%
Total Number of Responses: 68

2f. If so, trained in what and by whom?

It was reported that public health nurses have four year degrees plus additional training in assessments, such as NCAST, Denver II, Child and Teen Check-Up, EPSDT, Infant Follow Along, and Ages and Stages. In addition, training included areas of emphasis in home visiting, infant/child development, family health, family support, newborn assessment, immunizations, and home safety/injury prevention. It was reported that ECFE staff have four year degrees and ECFE licensure; ECSE staff have four year degrees and licensure in special education, speech therapy, etc.; and paraprofessionals are trained by public health nurses in observation, health, growth and development, common illnesses, family health, and family support.

3a. Does your local public health agency devote any Maternal & Child Health (MCH) funding directly to infants and their parents?

Yes: 90% Don't Know: 3% No Response: 7%
Total Number of Responses: 68

3b. If so, how are these funds used?

Survey respondents listed a variety of activities in prevention, early intervention, and safety promotion that are supported with MCH funds. These activities include parenting classes, family planning services, prenatal education and support, post partum home visits by paraprofessionals and nurses for high risk families, services for chronically ill children and children with special needs (including case management), interagency early intervention screening, and workshops for professionals. Many of the services for families are provided through home visits. One respondent wrote that, "funds are depleted each year. More funding would allow for more services."

4. Section 4 is the exhaustive list of risk to which respondents were asked to indicate if there are services in their community for parents and for infants—as well as whether they feel that the services are "sufficient."

Respondents reported that the most often encountered risk factors are:
1. fussy baby, feeding difficulties, sleeping problems, etc.
2. concerns regarding parental responses or expectations
3. parents who are experiencing multiple stress factors

4. parents who are isolated and lack social support

Numbers 1 and 2 received more "Yes" responses in answer to the question, "In your opinion, are these services sufficient?" than did numbers 3 and 4.

Out of the 137 responses we received, the questions with the highest number of "Don't Know" responses as to whether the survey participant felt that services are sufficient were: "hospitalization that causes separation" (61)—which also had the lowest number of "Yes" responses, "infants who experience trauma" (42), "relationship problems between infants and their caregivers" (41) and "parents who are experiencing extreme relationship or marital problems (41).

The three questions with the highest number of "yes" responses to the question, "In your opinion, are these services sufficient?" were: "infant/toddler with developmental delays" (98 responses), "genetic disorders" (79 responses), and "adolescent parents" (62 responses).

For the most part, respondents rated children and parent services about equally for the different questions. An exception to this was found in response to "parents who have emotional problems or mental retardation." A total of 36 out of the 137 respondents reported that there are children's services available in their communities, whereas 56 reported that there are parent's services available. Also, this question generated the largest number of "No" responses to the question as to whether services for children are "sufficient."

Following is the complete accounting of survey responses to the risk factors.

5. Do you have other services in your area that support infants and toddlers and their families?

In answer to this question respondents listed some of the same programs as were referred to elsewhere. What stood out here were the informal and what might be referred to as less intensive and/or specialized supports for families that were listed, such as daycare in centers and in homes, local volunteer and non-profit organizations, neighbors, and churches.

6a. Is there a follow-up after an initial referral?

Yes: 85% Don't Know: 9% No Response: 6%

Total Responses: 68

6b. Is there a tracking system in place?

Yes: 85% No: 6% Don't Know: 7% No Response: 2%

Total Responses: 68

A wide variety of tracking methods and systems were reported. Some counties described their systems as "manual," "not well integrated," and "informal," while others said their systems were "integrated" and "computerized." Representatives of several counties mentioned they are working on improving existing systems or are in the process of implementing new systems. In addition, some survey respondents reported that tracking depends on the agency and the origin of the referral or request, and that children are tracked only if they get into the system somehow.

Many of the specific tracking systems/programs mentioned were related to public health. Tracking was also done through IEICs, ECSEs (through IFSPs), ECFEs, Social Services and Family Service Collaboratives. Specific programs included Infant Follow Along, Baby Tracks, KIDS, Healthy Start, Ages and Stages, First Step, Families First, Healthy Families, Communities Caring for Children, Childfind, Child and Teen check-ups, immunizations and Part H.

7. "Where do you see the greatest need for resources for infant/toddler mental health services?"

Support and education for parents was cited frequently in response to the question about what survey respondents see as the greatest need for resources for infant/toddler mental health services. They expressed the concern that parents, professionals, and others in the community with whom parents interact need basic child development information, as well as an "understanding of the interaction between parents and children" and "reading infant cues." They pointed to the complexity of our society as a cause for this great need for support and education. They also emphasized the need for outreach—ways to connect with parents who may be in need of services. And, finally, they promoted a coordinated, accessible community system of services that links community resources to serve families. As one respondent put it, "I think a statewide system of screening at birth, universal home visit, and long term intensive home visits for those at risk needs to be developed. All this needs to be voluntary, but very attractive and accessible."

8. What role can the State of Minnesota play in supporting infant/toddler mental health in your community?

Survey respondents suggested that the State's role in infant mental health can be in leadership in "making infant mental health a priority" by increasing awareness about infant mental health and facilitating outreach to families. They also saw provision of training and technical support opportunities as a role for the State, as well as "mental health consultation." They suggested that the State facilitate the establishment of a network within each community to organize screening (including developing screening tools), referrals and assessment—and services for those families who can benefit from them. They think the State can lead the way in encouraging partnerships among agencies and diverse community resources to develop services that support infant/toddler mental health through incentive funding. And they urge the State to facilitate efforts to reduce barriers to services, especially by increasing flexibility in the criteria for receiving services. One barrier that was mentioned often is the "medical necessity" requirement for receiving assistance through Medical Assistance (M.A.). The need for increased funding for all programs, including prevention programs, was often mentioned in survey responses. "We don't have enough money to provide basic maternal child health services, let alone mental health," was one comment. Another respondent suggested that funding go to "programs that are proven to be effective."

Encourage the development of partnerships with community health centers; create money to be utilized for mental health consultation, outreach and direct service (wraparound)—so parents and children have access to mental health services .

9. Who should receive additional training and what type of training is needed to enhance infant/toddler mental health services?

A number of respondents stated that they feel that parents and all people who interact with families should receive training in infant/toddler mental health. Among those who were specifically cited to receive training were: pregnant women and their partners, parents, school personnel, early childhood professionals of all kinds, early childhood special education teachers, family and center-based child care professionals, Head Start personnel, hospital staff, family physicians, obstetricians, and pediatricians, medical clinic staff, public health nurses, county personnel, mental health workers, social workers, child protection workers, parent/family/Home Health Aides, WIC personnel, home visitors, paraprofessionals (specifically home visitors working with public health nurses), ECFE staff, adult basic education staff, law enforcement, foster care providers, administrators,

church leaders, community workers in schools, and junior high and high school students.

The types of training recommended by survey respondents included: awareness about infant mental health, information and support for families, all areas of infant/toddler development, infant cues and states, bonding and attachment, signs and symptoms of depression in infants and toddlers, the importance of the early years and involving the whole family, screening, referral and follow-up, working with families in crisis, information on "behavior" problems and how to help parents deal with difficulties with kids, intervention strategies, service management, and communication skills.

10. What other thoughts do you have about providing greater access to mental health services for infants and toddlers and their families?

One respondent voiced concern about one agency being identified with infant mental health, rather than a establishing a collaborative effort to address the issue. Another suggested that the stigma of the words "mental health services" may discourage parents from accessing services.

Following are a sampling of additional responses to this question.

I think we are just beginning to see the importance of early intervention.

We have a lot of pressure to place kids in special education due to adjustment problems that would be better treated by mental health professionals.

The need is great. We live in a complicated society where mental health needs are often overlooked. Mental health programs are just as important as any other program.

It seems that now services may be available to families at risk of abuse or with an identified special education delay. Too many families don't fit into either mold and so are denied access to these services. Also, many insurance plans don't cover mental health services, but families can't afford them out-of-pocket and don't meet financial criteria for funding assistance.

We need crisis nurseries, subsidized day care, doctors who recognize problems, etc. ...The list is long. After we know about (a child with mental health needs) they are often three to four years old.

Tear down the barriers/paperwork/misinformation about mental health in general. Families shouldn't have to be a part of a system (Social Services, Head Start, Early Childhood) in order to receive mental health information and services.

Appendix B

Summary of Focus Group Results

In order to better understand the ways in which different communities work collaboratively on issues affecting young children and their families, including the issue of infant/toddler mental health, a series of five focus groups were conducted in communities in Northwestern, Northeastern, and Southwestern Minnesota, and in the Twin Cities (Minneapolis/St. Paul) Metropolitan Area. The Interagency Early Intervention Committees (IEIC's) in each of these communities were asked if they would host a focus group. The IEIC's were chosen because they are interdisciplinary groups that focus on the birth to three population. Also, the IEIC structure was considered as a possible mechanism for developing a coordinated system for infant mental health services in Minnesota.

Following are collective summaries of the responses to each of the questions the groups were asked.

1. Have you reached consensus about the definition of "infant mental health"? If so, what is your definition and how did you come to it?

At the time of the focus groups, none of the IEIC's had reached consensus about a definition of infant mental health, but within the context of the focus group conversations most groups noted that infant mental health includes the emotional well-being of the infant or toddler, the quality of relationships between the child and caregiver, and the family environment—including "positive consistency" of care for the child. Several of the groups mentioned the need to expand awareness of infants' health beyond it's physical well-being. One group identified the lack of an agreed upon definition as a major problem. They feel that infant mental health can become a "catch all concept that is hard to deal with." "Diagnosing" infants was problematic for some, both in terms of its practicality and in terms of giving a child a "label," although one participant said, "From the parent's perspective, the sooner you get the diagnosis, the sooner you get the services."

2. How have you defined professional responsibilities for infant mental health services?

Most groups mentioned that currently, as well as in the past when their work was funded at a higher level, public health nurses are the primary force in infant health promotion. Through their contact with families, public health

nurses have served in screening and referral capacities when a problem is suspected.

Some groups listed a host of providers: social workers, educators, Tribal Councils, Public Health, special education, Head Start, medical personnel—as well as parents— in terms of responsibility for infant mental health. There were definite differences in approach to infant mental health services. Some spoke of local efforts such as an Interagency Review Team that takes in referrals and reviews ongoing cases from earlier referrals. Another group described their Healthy Families program that provides home visitors for families that are identified as "at risk." In one of the rural communities a lack of qualified professionals to provide therapeutic interventions was put forward as a major problem for them. In general, the groups indicated that many families who are in need of services are not receiving the assistance they need.

3. Are those who provide services doing so as part of their job?

Participants in all groups stated that those who are providing infant mental health services are doing so as part of their jobs.

4. What, if any, training do you provide to infant mental health service providers?

A number of training opportunities were listed by participants. Most of these trainings are discipline-specific. Some of them are related to infant/toddler mental health, but do not directly focus on that topic. Among those mentioned were: state-sponsored trainings for social workers, workshops on a variety of topics including attachment and child development provided to foster parents and day care providers, training on FAS/FAE for Head Start staff, a series (since discontinued) on NCAST for ECSE staff and day care providers, and specific training for a new Healthy Families program. It was mentioned that, " a lot is available on attachment and bonding...more is needed on what is health parenting behavior, on what infant mental health is, and when is a referral needed for the parent and/or the child." One region recently held a series of trainings on infant mental health, including a short course taught by Michael Trout. A number of disciplines were represented, including mental health professionals, nurses, and educators. The training was uniformly lauded as an example of the type of information that is needed by "everyone."

5. How are families referred to services?

When asked how families are referred to services, participants cited personnel from hospitals, clinics, child protection, ECFE, WIC programs, public health, child care, schools, and Head Start as key points for families to

receive referrals to services. Professionals from many disciplines are involved in the referral process, but it is not an organized, cross-disciplinary procedure. As one participant put it, "Someone recognizes a need, we refer to whoever we can, and we try to get as many people into the home as possible."

Others talked of the need for parents to be informed of where resources are. Some communities do have resource lists. But personnel in each system know their own systems, but not others, including whether or not families may be eligible for services. "As a provider it is difficult to understand and stay current" on the eligibility criteria.

6. Within what framework are issues such as the frequency and duration of services decided?

All groups confirmed that the financial framework is what determines the frequency and duration of services. With reduced financial and staff resources, as compared to even ten years ago, participants described the hard decisions that they face in providing services to families.

If the child meets the criteria for special education, there is some flexibility in meeting the needs of the family. "The IFSP has been helpful, especially if you have a good interdisciplinary team for the parent and the child," said one participant.

Several mentioned that social services "drop out when things are going well," which reduces ongoing support for the family. "In social services, after we drop out we wait for another call. For example, now we can predict that parents are going to have problems when their child reaches the age of about 15 months and becomes independent. However, the system is reactive rather than proactive."

Another participant summed it up by saying, "with (less funding) it is always a juggling act. Families always need more that we can afford."

7. Where are services provided?

Participants listed a variety of sites where services are delivered: hospitals, mental health departments/agencies, medical clinics, public health nursing clinics, community centers, ECFE classes, Head Start, schools, homes, foster homes, churches, and through traditional healing resources such as Native American sweat lodges. One participants stated that services are being delivered in "80 places or organizations or one, depending on how infant mental health is defined."

8. What type(s) of funding sources(s) do you use to support your infant mental health services? What additional or alternative sources do you think should be explored?

In response to the question about funding sources used for infant mental health services, participants cited a variety of options: Medical Assistance (M.A.), Title 20 social services funding, Children's Mental Health, special education (Part H or Part C), Part B for Head Start, school district general fund (for parent education), private insurance, Maternal and Child Health funding from the Minnesota Department of Health in "little, tiny pots of money," United Way, general county funding, Department of Human Services, and the Department of Children, Families and Learning. It was mentioned that county collaboratives can "open up grant dollars." A grant from the McKnight Foundation helped pay for a recent infant mental health training in one region. The Family Preservation Act was cited as one possible future source, as were community businesses.

9. What are the critical elements of your services—those which would have to be in place in any community providing these services?

The following is a combined list of critical elements of services discussed in the focus groups:

- a definition of infant mental health, its components, and "how it should look."
- leadership from the State in making infant mental health a priority and bringing attention and action to the issue of infant mental health
- awareness of infant mental health issues
- universal parent leave for one year
- universal home visiting
- screening/identification processes
- a referral system with knowledgeable personnel making referrals
- educational opportunities for parents that are accessible to them (including at the workplace and after regular work hours) and that promotes "good parenting"

- educational opportunities for teenagers
- prenatal education services
- adequate funding
- a reimbursement mechanism

What are the critical characteristics of infant mental health services?

- the ability to serve children without a diagnosis - like ECFE - prevention-focused
- asset-based services
- confidentiality
- trust
- community support for services and for those who participate in the services
- recognition that parents know their children best
- active participation of parents in the decision-making
- a continuous relationship between the family and one service provider
- cultural awareness and sensitivity - respect for traditional values, beliefs and methods
- collaborative efforts with all who work with family sharing responsibility for mental health issues
- a good working relationship between agencies and a flow of information between agencies so that all know what the others are doing

- well-trained providers
- ongoing training for providers
- a professional work support system so that those who are doing the work with families are supported themselves
- a flexible work schedule for service providers
- the recognition that infant mental health services are part of the professional's job description

10. What is the theoretical basis of your infant mental services? (for instance, is your focus primarily on the child? on the parent/child relationship? on the child within systems such as the family and neighborhood? on the adults in the child's life?)

Most of the focus groups reported that they focus on "all of the above." They emphasized that they "don't only focus on the child." One participant said, "It would be easier to focus just on the child because the other issues are overwhelming." But they all confirmed that they view the child and parents within the context of the family and community systems.

11. What are the barriers that you have encountered in providing infant mental health services?

The following barriers to providing infant mental health services were cited by participants:

- lack of adequate funding
- a lack of public awareness of infant mental health issues
- the social stigma of mental health/illness
- information about services does not reach the people for whom it is intended
- lack of awareness among professionals who see families regularly and are in a position to intervene or refer to services (An example given was physicians who take a "wait and see" approach or say, "I don't see a problem" when a diagnosis is needed.

- difficulties with "diagnosing" infant mental health issues
- a deficit-based system of services
- apathy on the part of parents or mistrustful parents
- families not at home, refusing to open the door when the provider comes to visit the family at home, or families that miss appointments
- communication and transportation barriers (families without telephones and/or cars)
- systems/policies that work against each other
- hierarchy of family needs (physical needs of food, clothing, shelter, and safety must be met too)
- support services that end at 4 or 6 PM
- a lack of training for providers
- there are no specialists to whom families can be referred
- infant mental health services are not included in job descriptions
- a lack of agency acknowledgment that infant mental health is a priority
- a lack of a reimbursement mechanism for providing services

12. Have you identified problems or issues related to infant mental health that have not received attention by researchers, policy makers, and program administrators?

The problems and issues that were identified by the focus groups as not having received attention can be divided into two broad categories, leadership/systems change and parenting/child care. The issues were often stated in terms of what <u>should</u> be done that isn't at this point.

The first category of issues has to do with leadership and systems change. These issues included:

- education of the general public regarding infant mental health issues ("most people assume that infants have good mental health, or think that it's not relevant for infants")

- education of policy makers so they see the need for infant mental health services and so the put resources into this effort

- prevention should be valued by the community - there should be "advocacy to provide prevention services"

- infant mental health should be a State priority "and be mandated like Children's Mental Health - mandate can drive services and contribute to creative financing"

- more research should be conducted on "what we need to be successful" and on "resiliency factors" - "summarize (the information) in a meaningful form" and "have administrators use this in program design"

- the identification process is divisive - we need more ways of identifying people without labeling them

- short hospital stays after the birth of a child leave no time for education of the parents, or "to discover if bonding has occurred"

The second category of issues centers on parenting and child care:

- parents don't receive enough information about infant mental health

- there is a lack of parent accountability - for those who receive financial assistance, "it should be necessary to learn best parenting or best nurturing practices"

- as a society we don't value the role of parent - this is evident in family leave policies, or the lack thereof - in other countries work policies are very different

- there should be a tax incentive for staying at home with children, rather than returning to work

- there is a lack of quality child care - on-site child care at the workplace should be encouraged

- job sharing should be promoted as a way to help parents with child care

- the problem of developmentally disabled parents - the mental and emotional capabilities of parents is an issue - "This is a difficult issue. It brings up the right to have kids and the right to raise them."

13. What specific services should comprise the "minimum threshold" of services that should be in place for all families?

The following responses were offered regarding a "minimum threshold" of services that should be in place for all families:

- education about infants for parents through classes covering "the complexity of relationships, what changes occur and can be expected with babies" (these classes must be offered in various languages)

- a more holistic approach to services for women, children and men so that all members of the family are served

- course work in infant mental health should be made a graduation requirement

- early identification - a way to screen for potential problems

- work in cooperation with the medical community to find a way for physicians to refer to an infant screener

- make changes to promote infant mental health in the birthing/medical field

- mentors available on an information/crisis line

- access to a child psychiatrist with a vested interest in the community

- postpartum home visit to look at the "whole picture" of the family

- home visits extended throughout birth to age five of the child for preventive services

- good assessment information (there should be a functional assessment - "to measure as (a child) grows"

- a payment mechanism for services

- a "one person 'case management problem solving model' to avoid duplication of services"

14. Are there other things that we haven't discussed that that you would like to add regarding the topic of infant mental health?

In response to this question a participant in one group said, "Within our mental health agency it took determined people to advocate for (the importance of infant mental health) because of the many other competing interests. However, I believe that if these services were more widely available we could get rid of our junior high day treatment programs."

Appendix C

Infant Mental Health Services in Other States

Arizona

Arizona initiated a strategic planning process for infant mental health services in 1994. They reviewed the current status of services in Arizona at that time and looked at research and services in other states. Their decision was to integrate services through existing programs. They now have a plan for how they envision providing services. They plan to screen for families that need services via all existing programs and through all hospitals and birth facilities using a standardized methodology and common screening tool. They have included a full range of activities in their strategic plan, from public awareness campaigns and prevention services through intervention, training and continuos improvement.

Georgia

Georgia's *Starting Points: Model System of Family Contact, Support and Service Coordination* is a significant portion of a larger system designed to provide early and periodic contact with all families in Georgia. This portion begins with the birth of the child. Corresponding models are being designed for outreach during pregnancy and contact with all children at school entry. In this model each hospital/community develops strategies to provide information from a prenatal assessment to the hospital and each hospital/community determines how to screen all newborns using a standardized (paper) screening instrument for risk factors. Families at both higher and lower risk receive a face-to-face interview. For those at higher risk, a standardized assessment is used to determine family strengths, resources, and needs. Currently the Kemp Family Stress Index is being used. Referrals are based on the results of this assessment. Lower risk families complete the screening but not the full assessment. Support services are provided during the visit and referrals are made, if appropriate. Home visitation with 72 hours of discharge from the hospitalization is available for every newborn to provide assessment of mother and child, offer anticipatory guidance for the family, promote mother-baby "bonding," and ensure linkage to primary health care providers and other resources.

The *Children 1st* program provides ongoing contact with the family until the child's third birthday through the monitoring and referral network managed by public health departments.

Hawaii

Hawaii's *Healthy Start* is an early intervention program administered through the department of Health, Personal Health Services Administration, Family Health Services Division, Maternal and Child Health Branch. It was conceived as a program to prevent child abuse and neglect. The program offers systematic screening for families abound the birth of a newborn. Most programs use the Kemp Family Stress Index as a screener. Two types of paraprofessionals (with different skill sets) are employed: one to administer screening and the other to conduct home visits. Families identified with high risk factors are offered weekly home visitation services. Families are followed until the child reaches the age of five. The Department contracts with seven private community agencies to provide services. The *Healthy Start* program goals are to: strengthen family functioning, enhance parent/child interaction and positive parenting, promote optimal child development, assure a health care home and full immunization, assure use of community resources including family planning, and avert child abuse and neglect.

Michigan

Initiated in the early 1970's, the Michigan intervention model has been installed in 35 locations through community health boards and a few non-public agencies throughout the state. While they share common characteristics, the programs vary in their processes and in the populations they serve. There are multiple points of intake. Some programs limit enrollment to a specific population, such as low birth weight babies, adolescent mothers, or Medicaid-eligible families. The Borgess Interaction Assessment (BIA) is used to screen in the hospital. The service strategy is a voluntary home visiting model that is initiated within the first six weeks of the birth. Some programs limit service to one year, while others extend services for some families into a second and third year. A full range of interventions are involved in meeting the needs of the family: supportive counseling, developmental guidance about infant behavior and child care practices (with reinforcement for appropriate behavior), resolution of material needs and advocacy, conscious modeling and encouragement for problem solving and planning ahead, development of a stable network of social support, and resolution of intrapsychic issues that are impeding parent-infant attachment. An infant mental health specialist establishes and maintains a relationship with the family throughout the intervention process. The focus is on the parent-infant dyad, their capacities for attachment and the risks that they face. The infant is at the center of the intervention and the infant mental health specialist supports and nurtures the parent as the primary caregiver.

South Carolina

South Carolina is addressing the need for training in infant mental health through three initiatives. The target audience for these projects are the professionals serving birth to three year olds with disabilities and/or developmental delays and their families through *BabyNet* (Part C). These initiatives are as follows:

Mental Health Counselors: Several parts the state have been assigned *BabyNet* Mental Health Counselors through local mental health centers to provide services (evaluation and treatment) for families who have infants or toddlers with special needs. They work intensively with families dealing with infant mental health and/or family issues as well as provide consultation to early intervention professionals in their area.

Mental Health Roundtables: In several local communities across the state, mental health roundtables have been established as a forum for early intervention professionals to address challenging infant and/or family mental health issues. The Multi-Systemic Treatment approach promotes a sensitive and respectful discussion format so professionals can problem-solve and develop strategies together to more effectively work with the families they serve. Typically a roundtable is held monthly for 1-2 hours at lunch time.

Mental Health In Birth to 6 Year Old Children Curriculum: Written materials to address mental health issues for young children have been prepared as part of a set of individualized, self-paced training modules. Recommended practicum experiences, readings and videotapes are included as well as information on the following topics: stages of typical social-emotional development; challenging behaviors; assessment; diagnoses; resources; and intervention approaches, including discipline strategies.

MINNESOTA INFANT MENTAL HEALTH SERVICES FEASIBILITY STUDY

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